PHYSICIAN GROUPS – THE NEXT ENFORCEMENT FRONTIER FOR HEALTHCARE PROVIDER MERGERS?

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Physician Groups – The Next Enforcement Frontier for Healthcare Provider Mergers?

By Sara Razi, Steven Tenn & Omar Farooque

The Federal Trade Commission's recent announcement that it will be undertaking a retrospective study of physician group consolidations may signal an increased focus on physician group mergers in the coming years. In this article, we explore how mergers involving physician groups pose unique issues and how the FTC's approach to these transactions may be impacted by their forthcoming physician merger retrospectives. Physician mobility may have important implications regarding barriers to entry and repositioning. Physician mergers may also lead to non-standard remedies, such as the release of physicians from non-compete agreements. Vertical theories such as foreclosure of rivals through altered patient referral patterns or limited competitor access to physicians may also receive scrutiny in these types of transactions.

I. INTRODUCTION

Nearly 20 years ago, the Federal Trade Commission ("FTC") set out to revitalize its hospital merger enforcement program. After the FTC and the U.S. Department of Justice ("DOJ") lost a series of hospital merger litigations in the 1990's, the FTC invested in its hospital merger enforcement program by starting a new group within its Bureau of Competition, the Merger Litigation Task Force (now known as Mergers IV).[2] Together with the FTC's Bureau of Economics, they undertook a series of merger retrospectives to assess the competitive impact of consummated hospital mergers as a step towards developing a new future for the FTC's hospital merger enforcement program.[3]

Two of the authors of this article were directly involved in those merger retrospectives – one as a lawyer representing a healthcare system in a consummated hospital acquisition, the other as an FTC economist. We saw first-hand how the FTC's merger retrospectives changed the way FTC staff thought about hospital mergers.[4] This, in turn, led to further changes as lawyers and economists retained by the merging parties in subsequent hospital mergers adjusted to the FTC's new approach to these transactions.

The FTC's approach to healthcare provider mergers may be on the cusp of its next evolution, with the agency looking for new issues to explore and new challenges to overcome. We believe this "next frontier" is likely to focus significantly on transactions involving physician groups. The FTC has been less active in physician group mergers compared to hospital mergers, with the agency taking enforcement action in only a handful of physician merger matters to date (see Section II). The agency's interest in physician mergers may be rising, however, given the FTC's recent announcement that it will be undertaking a retrospective study of physician group consolidations from the prior five years.[5,6]

In anticipation of greater FTC interest in physician group mergers going forward, we provide our perspective on key issues in the antitrust evaluation of such transactions. We consider how physician group mergers raise issues that are distinct from those in other healthcare provider mergers, and how the FTC's approach to these transactions may be impacted by their forthcoming physician merger retrospectives.

II. PHYSICIAN MERGER ENFORCEMENT BACKGROUND

To date, the FTC has challenged five acquisitions involving physician groups. The first came in 2012 when the FTC challenged Renown Health's ("Renown's") consummated acquisition of Reno Heart Physicians ("RHP"), a physician group specializing in cardiology in the Reno, Nevada area.[7] The FTC alleged that the transaction resulted in Renown employing 97 percent of cardiologists in the Reno area at the time the transaction was consummated. The consent agreement in this matter required that Renown release up to 10 cardiologists from non-compete clauses, allowing them to join competing practices.

Since that time the FTC has challenged three additional transactions in which a hospital system attempted to acquire a physician group. In 2013, the FTC and State of Idaho challenged St. Luke's Health System's ("St. Luke's") consummated acquisition of Saltzer Medical Group ("Saltzer"), respectively a hospital system and physician group offering services in Nampa, Idaho.[8] The plaintiffs alleged that the transaction would lead to anticompetitive effects related to primary care physician services. The district court ruling sided with the plaintiffs and the ruling was upheld in the subsequent appeal. St. Luke's was required to divest Saltzer.

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2 See https://www.ftc.gov/news-events/press-releases/2002/08/federal-trade-commission-announces-formation-merger-litigation.

3 The public portions of the FTC's hospital merger retrospectives were published in 2011 in a series of articles in a special issue of the International Journal of the Economics of Business.

4 For an introduction to the types of models commonly used to evaluate hospital (and physician) mergers, see Steven Tenn (2019), "Introduction to the Economic Analysis of Hospital Mergers," in the Winter Newsletter of the Economics Committee of the American Bar Association's Section of Antitrust Law.

5 See https://www.ftc.gov/news-events/press-releases/2021/01/ftc-study-impact-physician-group-healthcare-facility-mergers. The FTC will also use this study to assess consummated healthcare facility transactions.

6 The DOJ and FTC revised their Vertical Merger Guidelines in 2020. While these guidelines do not particularly focus on physician group acquisitions, vertical integration is becoming increasingly prevalent in healthcare. Transactions that combine physician groups with other service providers, such as hospitals and health plans, potentially raise vertical merger issues (see Section IV). The revised Vertical Merger Guidelines are available at https://www.ftc.gov/system/files/documents/reports/us-department-justice-federal-trade-commission-vertical-merger-guidelines/vertical_merger_guidelines_6-30-20.pdf.

7 Materials related to this case are available at https://www.ftc.gov/enforcement/cases-proceedings/1110101/renown-health-matter.

8 Materials related to this case are available at https://www.ftc.gov/enforcement/cases-proceedings/121-0069/st-lukes-health-system-ltd-saltzer-medical-group-pa.

In 2016, the FTC challenged CentraCare Health's ("CentraCare's") proposed acquisition of St. Cloud Medical Group ("SCMG"), respectively a hospital system and physician group offering services in the St. Cloud, Minnesota area. The FTC alleged that the transaction would cause anticompetitive effects related to the provision of adult primary care, pediatric, and OB/GYN services.[9] However, the FTC concluded that SCMG satisfied the requirements for being a failing firm. Similar to *Renown-RHP*, the consent agreement in this matter required that CentraCare release a limited number of physicians from non-compete clauses, allowing them to join competing practices.

In 2017, the FTC and State of North Dakota challenged Sanford Health's proposed acquisition of Mid Dakota Clinic, respectively a hospital system and physician-owned professional corporation offering services in the Bismarck, North Dakota area.[10] The FTC alleged that the transaction would cause anticompetitive effects related to the provision of adult primary care, pediatric, OB/GYN, and general surgery services. The district court ruling sided with the plaintiffs and the ruling was upheld in the subsequent appeal. The parties abandoned the transaction.

In the most recent case to date, in 2019 the FTC challenged UnitedHealth Group's ("UnitedHealth's") proposed acquisition of DaVita Medical Group.[11] The FTC's complaint alleged that both firms offered Managed Care Provider Organization services in the Las Vegas, Nevada area through their respective physician groups. The complaint also raised vertical concerns related to UnitedHealth's Medicare Advantage plans. The consent agreement in this matter required the divestiture of HealthCare Partners of Nevada, DaVita Medical Group's healthcare provider organization in the Las Vegas area.

III. HORIZONTAL MERGER ISSUES

Physician group transactions potentially raise horizontal merger concerns for the FTC when they result in significantly competing physician groups being combined under common ownership (or other contractual relationships in which physician groups effectively operate as a single unit). Examples of this include when one physician group acquires another, or when a hospital system that already employs physicians acquires a physician practice with which it significantly competes.

The horizontal concern potentially raised by physician group mergers is that the merging parties may impose a significant competitive constraint on each other pre-merger and the removal of that constraint post-merger may allegedly result in anticompetitive effects such as higher prices or lower quality services. For this reason, the key issues when assessing a proposed physician merger are similar to those that arise in other types of healthcare provider transactions, including hospital mergers. Nonetheless, as discussed below, certain factors make physician mergers "special" and raise unique questions when undertaking antitrust assessments of such transactions.

A. Physician Mobility – Implications for Entry and Repositioning

A unique aspect of physician group mergers is that the primary "asset" involved is the professional services offered by the practice.[12] While physician group acquisitions may involve some tangible assets, such as office space and medical equipment, antitrust analyses generally focus on the physicians involved since they are the key driver of a physician practice. This is an important difference with hospital mergers where a key asset is building infrastructure, which may be very expensive to expand, reposition, or, more drastically, move to a different location. Individual physicians, on the other hand, are potentially quite mobile and can be added (or subtracted) from physician groups in increments of less than a single full-time worker by using part-time employees.

Physician mobility may reduce barriers to entry or repositioning, due to the ability of other physician groups to attract additional physicians from other geographies. This is important because, absent significant barriers to entry, even a merger that significantly lessens competition in the short run may have little long run impact, potentially making FTC enforcement action unnecessary for an otherwise challenging transaction.[13]

9 Materials related to this case are available at https://www.ftc.gov/enforcement/cases-proceedings/161-0096/centracare-health-system.

10 Materials related to this case are available at https://www.ftc.gov/enforcement/cases-proceedings/171-0019/sanford-healthsanford-bismarckmid-dakota-clinic.

11 Materials related to this case are available at https://www.ftc.gov/enforcement/cases-proceedings/181-0057/unitedhealth-groupdavita-matter.

12 Physician group acquisitions often involve non-compete agreements that prevent the merging parties' physicians from practicing in a competing physician group in the same geographic area for some time period. Non-compete agreements are an area of interest for the FTC, which recently held a public workshop on the topic. See https://www.ftc.gov/news-events/events-calendar/non-competes-workplace-examining-antitrust-consumer-protection-issues.

13 See Section 9 of the DOJ and FTC's 2010 Horizontal Merger Guidelines, available at https://www.ftc.gov/sites/default/files/attachments/merger-review/100819hmg.pdf.

As discussed earlier in Section II, the FTC has challenged relatively few physician group transactions. The transactions the agency has challenged often allege very high combined shares for the merging parties. One explanation is that barriers to entry in physician transactions are often viewed as being sufficiently low that they are expected to offset all but the most anticompetitive transactions, e.g. when the merging parties are the primary providers of a given physician service in an area.

Whether or not there are significant barriers to physician entry or repositioning depends on the specific facts in a given matter. It may depend, in part, on the physician specialty at issue and how physicians in that specialty typically acquire patients. For example, entry for a specialist who generally acquires new patients through encounters in a hospital's emergency room may be easier than for a primary care physician who slowly builds up a patient base through referrals by their existing patients to their friends and family. Similarly, barriers to entry may be significantly lower if entry is sponsored by a hospital or health plan that can drive patients to a new entrant.

Barriers to entry may be particularly low in transactions involving a small number of physicians. For example, in the *Renown-RHP* matter the FTC alleged that the transaction was to near monopoly of cardiologists in Reno, with the parties having a combined share of 97 percent. This case was unusual in that the transaction was consummated prior to the FTC completing its investigation of the transaction. Between the time of the transaction and when the FTC issued its complaint, some of the merging parties' cardiologists moved away from the area and additional competing cardiologists moved into the Reno area. According to the FTC's complaint, the net impact of these physician movements is that the parties' combined share fell by nearly 10 percentage points.[14] This highlights the potential difficulty faced by the FTC in challenging physician mergers even when a transaction initially results in a near monopoly.

Barriers to repositioning by physicians already practicing in a given area may also be relatively low in certain circumstances. It has become increasingly common for physicians to practice from multiple locations. This may allow a small number of physicians to provide a local presence across a relatively wide geography. Low repositioning barriers may be more likely to offset anticompetitive effects in situations where competing physician groups can easily open a new location and utilize their existing personnel to staff it.

The United States is a large country with more than one million physicians.[15] When hospitals, health plans, or competing physician groups have an incentive to sponsor entry, they can potentially draw on this large labor pool. Of course, the FTC may contend that the key issue is not whether it is theoretically possible for physicians outside the geographic area to enter, but rather whether incentives are such that entry is likely to occur and will be sufficient to offset potential anticompetitive effects in a timely manner.

We anticipate that one of the key issues that the FTC may be exploring in its forthcoming physician merger retrospectives is whether entry materialized in matters where the agency allowed transactions to proceed under the belief that entry barriers were sufficiently low that anticompetitive effects would not occur. If the results from the FTC's retrospectives suggest that entry barriers in those cases were significantly higher than expected, then we may see the FTC looking more closely at a wider range of physician group transactions in the future.

B. Merger Remedies

In two physician group matters, *Renown-RHP* and *CentraCare-SCMG*, the FTC accepted a remedy in which the merging parties agreed to remove non-compete agreements for a certain number of their physicians, allowing them to join competing practices. This remedy is non-traditional since there may be little economic incentive for physicians to leave the combined firm if a given transaction is allegedly anticompetitive and would, in theory, allow those physicians to receive higher reimbursement from health plans post-merger if they remained employed with the merging parties.

The FTC's willingness to engage in such a remedy potentially highlights a key difference between the behavior of firms and the behavior of individual people. Typically, antitrust agencies and economists assume that firms (generally) pursue profit maximization and will take actions which promote that interest. In contrast, physicians are people who may base their employment decisions on both economic factors, such as their reimbursement rates from health plans, and non-economic factors that impact their quality of life. For example, a physician who has historically practiced at one hospital may not want to be employed by a competing hospital that would expect them to primarily practice there, even if this would result in meaningful economic benefits. In the *Renown-RHP* matter, for example, the release of non-competes as a remedy appeared to be successful. Initially there were two significant cardiology practices in the Reno area and both were acquired by the same hospital

14 FTC complaint in *Renown-RHP* at 4, available at https://www.ftc.gov/sites/default/files/documents/cases/2012/08/120806renownhealthcmpt.pdf.

15 See https://www.kff.org/other/state-indicator/total-active-physicians.

system. Following the FTC's remedy and the release of non-competes for certain cardiologists, there were three significant competing cardiology practices in the Reno area (more than the two that existed pre-merger).[16]

Another potential reason why the FTC has been more willing to accept non-standard remedies in physician matters is that blocking an allegedly anticompetitive transaction may result in undesirable outcomes. Specifically, if two physician groups are prohibited from merging, individual physicians may gradually switch employment from one practice to the other until a significant portion of the two practices are effectively combined. As a practical matter, it may be difficult for the FTC to investigate changes in physician concentration driven by the employment decisions of individual physicians. Moreover, regulating the ability of a given physician group to hire or fire employees is a behavioral remedy, which the FTC has sparingly relied upon. Going forward, it is an open question whether the FTC will show greater willingness to investigate, and potentially seek enforcement action, in situations involving the employment decisions of individual physicians.

IV. VERTICAL MERGER ISSUES

In addition to the potential horizontal concerns resulting from mergers of physician groups discussed in the previous section, vertical implications may also arise from physician group transactions. Below, we discuss key theories the FTC may consider when physician groups are acquired by either hospitals or health plans.

A. Foreclosure of Rival Hospitals Through Physician Referrals

Competition for physician referrals is non-price based since anti-kickback statutes prevent direct payment for physician referrals.[17] For example, a primary care physician may refer to specialists with good reputations. Similarly, a physician may admit patients to a hospital that is conveniently located near to their office.

The FTC may consider whether a physician group acquisition by a hospital system may impact physician referrals by altering the incentives of the acquired physician group. For example, the acquiring system may provide guidelines or otherwise encourage referrals to affiliated physicians and may encourage patients be admitted to hospitals owned by the system. Alternatively, primary care physicians may prefer to refer patients to affiliated specialists because doing so may offer greater ease in coordinating care or other clinical benefits. As such, it may be difficult for the FTC to demonstrate that any change in referral patterns were the result of a change in competitive incentives rather than other factors.

In the *St. Luke's-Saltzer* litigation, for example, the FTC and State of Idaho argued that the market power in adult primary care services that St. Luke's would gain subsequent to acquiring Saltzer would result in foreclosure in general acute care hospital services and orthopedic surgery services.[18] The plaintiffs alleged that St. Luke's could foreclose rival hospital systems from the provision of these services by redirecting referrals by Saltzer primary care physicians away from rival hospital systems to St. Luke's. In making this argument the plaintiffs referred to both documentary evidence, such as documents indicating an expectation that post-merger Saltzer primary care physicians would shift referral patterns to St. Luke's affiliated providers of these services, and data showing similar patterns at physician group practices previously acquired by St. Luke's.

In the *St. Luke's-Saltzer* litigation, the physician referral concern was seemingly an "add on" issue that was secondary to the core concern that the horizontal overlap between St. Luke's and Saltzer in primary care physician services would result in anticompetitive effects post-merger. Since any physician group acquisition may potentially impact referral patterns, it remains to be seen whether the FTC will bring a complaint in a situation without meaningful horizontal consolidation and where a vertical physician referral concern is the primary competitive issue.

16 Following the release of non-competes, a number of cardiologists left Renown and joined practices affiliated with two other hospitals in the area, Saint Mary's Cardiology and Northern Nevada Medical Group. See https://www.saintmarysreno.com/news/2012/december/saint-marys-cardiology-welcome-five-additional-c and https://thisisreno.com/2012/12/northern-nevada-medical-group-announces-three-new-cardiologists.

17 See, e.g. the federal Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b), available at https://www.law.cornell.edu/uscode/text/42/1320a-7b.

18 Plaintiff's Pretrial Memorandum in *St. Luke's-Saltzer* at 26-33, available at https://www.ftc.gov/system/files/documents/cases/130910stlukepretrialmemo.pdf.

We anticipate that the FTC may explore in its forthcoming physician merger retrospectives how physician referral patterns change after a physician group is acquired by a hospital, and more importantly, whether those changes had clear pro- or anticompetitive effects. If the retrospective results are mixed, then it may be the case that this will largely remain a supplemental theory of harm in transactions where the particular facts warrant and there is also significant horizontal consolidation in physician services.

B. Foreclosure of Rival Hospitals to Access to Physicians

Hospital services are often rendered in conjunction with related physician services. For example, a hospital that offers inpatient cardiology services needs cardiologists to admit and treat their patients at that hospital. For this reason, the FTC may examine whether physician acquisitions by hospital systems can potentially foreclose rival hospitals with respect to hospital and other non-physician services.

Using the *Renown-RHP* transaction as an example, the question may arise whether the employment of nearly all cardiologists in Reno might allow Renown to prevent other hospitals from competing in inpatient cardiology services so long as Renown's cardiologists only practiced at Renown's hospitals.

A key issue in assessing this type of competitive concern is whether entry barriers are sufficiently low to offset any anticompetitive effects. As discussed earlier, entry barriers are likely lower in situations where a hospital system (or other entity) has a strong incentive to sponsor entry. For example, a hospital system may be willing to use a high salary to recruit physicians to the area if the alternative is that the hospital would be limited in its ability to offer profitable hospital services.

C. Foreclosure of Rival Health Plans

Vertical issues may also arise when physician groups are acquired by health plans. For example, in 2019 the FTC issued a complaint related to the acquisition of DaVita Medical Group by UnitedHealth.[19] The complaint alleged that, prior to the acquisition, UnitedHealth and DaVita Medical Group were the two largest suppliers of Managed Care Provider Organization services in the Las Vegas area to health plans offering Medicare Advantage plans. As part of these services, primary care and specialty physicians were employed or affiliated with both UnitedHealth and DaVita Medical Group. In its complaint, the FTC alleged that the merger would result in anticompetitive effects in the form of raising costs or foreclosure of UnitedHealth's rivals that offer Medicare Advantage plans in the Las Vegas area.[20]

While currently many health plans do not employ large numbers of physicians, trends toward vertical consolidation have made this more common, e.g. larger healthcare systems may both employ physicians and offer health plans. As this trend continues and given the recent update of the DOJ and FTC's Vertical Merger Guidelines, we anticipate that the FTC may look more closely at transactions in which physician groups are acquired by health plans.

V. CONCLUSION

Physician group consolidation potentially raises both horizontal issues for mergers between physician groups and vertical issues for physician group acquisitions by hospital systems and health plans. Our expectation is that the FTC's general approach to physician group mergers will continue as the healthcare industry evolves. But, the agency will likely adapt to changing industry conditions by revisiting old issues and exploring new ones, particularly as the FTC assesses the competitive impact of prior transactions and reconsiders how physician group transactions should be evaluated. In this article we have highlighted issues that we believe will be important going forward and prepare to evaluate and respond to others that may develop in the future.

19 Available at https://www.ftc.gov/system/files/documents/cases/181_0057_c4677_united_davita_complaint.pdf.

20 FTC complaint in *UnitedHealth-DaVita* at 4-5.

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